5160 Standard DRG Group Rates

A standard DRG group rate is the payment rate for a DRG weight of one (1.00) before providing any hospital-specific rate adjustments. Hospital-specific adjustments and allowances are applied to the standard DRG group rate to calculate each hospital's specific DRG base rate. Two separate group rates are used - one for acute care hospitals, another for hospital institutions for mental disease (IMDs).

Enrollment in the HMO Preferred Enrollment Initiative (PEI) has been mandatory for over ten years for Milwaukee County Medicaid recipients in certain medical status categories such as those for children and mothers. WMP recipients not mandated for HMO coverage are in general, but not limited to, aged and disabled. Because the non-HMO, fee-for-service Medicaid population in Milwaukee requires more intensive medical care and is more costly to care for than the fee-for-service Medicaid population in other counties, the standard DRG group rates will be 10% greater for Milwaukee County hospitals than for hospitals in other counties to allow for any HMO adverse selection occurring in Milwaukee. If the HMO/PEI ceases to be mandatory in Milwaukee County, the WMAP will eliminate the Milwaukee county-wide adverse selection adjustment from hospital-specific DRG base rates. A specific hospital may request an administrative adjustment under section 11900, item I, "Adjustment for PEI Ceasing to be Mandatory."

5200 HOSPITAL-SPECIFIC DRG BASE RATE

5210 Calculation Of Hospital-Specific DRG Base Rate, General

The "hospital-specific DRG base rates" is calculated as follows. Detailed descriptions of each element of the calculation follow this general description. An example of the calculation is in the appendix, section 22000.

The standard DRG group rate appropriate for the hospital is selected according to section 5160.

The labor portion of that group rate will be adjusted by the wage area index applicable to the hospital. The sum of the adjusted labor portion and non-labor portion is the total labor adjusted group rate. Section 5220 describes the wage area adjustment index.

The total labor adjusted group rate will be multiplied by the allowed adjustment percentage for each of the following adjustments for which the hospital may qualify: disproportionate share described in section 5240, rural location described in section 5260, and IMD hospital length of stay adjustment described in section 5270. Compound multiplication will be used, meaning that each successive product will be multiplied by the adjustment percentage added to one (1.00). Added to this adjusted rate is a hospital's specific base payment for capital and a hospital's specific base payment for direct costs of a medical education program, described in sections 5400 and 5500.

The result is the "hospital-specific DRG base rate".

5220 Wage Area Adjustment Index

5221 Introduction.
The standard DRG group rate applicable to a hospital will be adjusted by a wage area index. This subsection describes how the Department develops wage area indices and which index will be applied to a specific hospital. The wage area indices which are to be used for the current annual rate update are listed in appendix §27000.

5222 Wage Area Classification.

Areas. Wage areas are identified by the metropolitan statistical areas (MSAs) and the rural areas which are used by CMS in the Medicare program as of March 31 prior to the beginning of each rate year. These wage areas in Wisconsin are defined by the counties in each wage area. The Milwaukee MSA includes four counties. The Department has divided the Milwaukee MSA into two wage areas, a Milwaukee county only wage area and an Ozaukee-Washington-Waukesha counties' wage area.

Reclassification. A hospital is originally classified to the wage area in which it is physically located. However, if the Medicare Geographic Classification Review Board has reclassified a hospital to a wage area, other than the area of its physical location, the hospital may request the Department to recognize the reclassification for determining WMAP reimbursement rates. A written request for reclassification must be delivered to the Department by April 30 prior to the beginning of a new rate year. (For details, see administrative adjustment under section 11900, item F, "Adjustment to Hospital Wage Area".) For any hospital Medicare reclassified to the Milwaukee MSA, the Department will reclassify to the Ozaukee-Washington-Waukesha county wage area, not the Milwaukee county only wage area.

After all reclassifications are finalized for any rate year, hospitals in a wage area will be referred to as either,

(1) "remaining original hospitals" which are hospitals physically located in the wage area and which have not been reclassified to or from the wage area, or
(2) "reclassified hospitals" which are hospitals not physically located in the wage area but which have been reclassified to it.

5223 Calculation of Wage Area Indices. The Department will develop wage area indices based on hospital wage data available through the federal Centers for Medicare & Medicaid Services (CMS). Specifications identifying the CMS wage data used for the current rate year indices is identified in appendix 27000. For hospitals for which CMS has no data, such as childrens hospitals and IMDs, the Department may use data from other sources, if available. The developed indices will reflect the reclassification of hospitals out of a wage area and into another wage area.

Only wage data from hospitals certified as providers for the WMAP will be used. For determining indices for border status hospitals, both major and minor border status hospitals in each wage area will be used.

The following hospitals are not included in the calculation of wage indices.

(1) Hospitals not covered by the DRG payment system (see section 5020).
(2) Hospitals in Wisconsin designated as critical access hospitals as of September 30 immediately preceding the beginning of the rate year, For example, for the rate year beginning July 1, 2003, hospitals designated CAH as of September 30, 2002 are excluded.
(3) Hospitals known to be closed or to have discontinued operating as a hospital as of September 30 immediately preceding the beginning of the rate year, not including hospitals combining or merging with another hospital.
(4) Out-of-state hospitals which do not have border-status with the Wisconsin Medicaid program.

A statewide average wage rate will be calculated using wage data from WMAP certified hospitals located in Wisconsin. The average wage index for each wage area shall be the ratio of the average wage for the respective wage area to the statewide average wage. The statewide rate, in essence, has a 1.00 index. A wage area index of 1.05 means that the average wage rate for the area is 5% greater than the statewide average. A wage area index of .90 means that the area's average wage rate is 10% lesser than the statewide average.

The average statewide and area wage rates shall be the average of individual hospitals' average wage weighted by the individual hospitals' amount of staff. As a result, larger hospitals will have a greater impact on the statewide and area average wage rate than smaller hospitals.

For each wage area, three indices will be calculated:

(1) a "composite" index which includes wages for the original remaining hospitals and the hospitals re-classified to the wage area,
(2) an "original remaining hospitals'" index based on wages of only the original remaining hospitals in a wage area, and
(3) a "reclassified hospitals'" index based on wages of only the hospitals reclassified to the wage area.

5224 Determining Applicable Index.
If the composite index is significantly lesser than the index for the original remaining hospitals in the wage area, then the index for the original remaining hospitals will be applied only to the originally remaining hospitals in the wage area. The reclassified hospitals' index will be applied only to hospitals reclassified to the wage area.

If the composite index for a wage area is not significantly lesser than the index for original remaining hospitals in the wage area, then the composite index shall be applied to both the original remaining hospitals and the hospitals reclassified to the wage area.

Significantly lesser means the composite index for a wage area is lower than the index of original remaining hospitals in the wage area by an amount exceeding one-percent (1%) of the index for the original remaining hospitals in the wage area.

The index applied to any hospital located in Wisconsin shall not be lesser than the rural Wisconsin index as determined under section 5225.

5225 Rural Wage Area Indices.
The wage index for the Wisconsin rural area will be based on wage data for only the original remaining hospitals in the rural area and will not include hospitals reclassified from or to the Wisconsin rural area. The wage index for the rural areas of other states will be based on wage data for only the original remaining hospitals in the rural area which are WMAP border status hospitals.

5240 Disproportionate Share Adjustment Percentage

5241 General.
The special payment adjustment described in this section 5240, specifically subsections 5241 through 5248, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

Extra payments are provided to hospitals that provide a disproportionate share of services to Medicaid and low-income patients. A hospital may qualify for a disproportionate share adjustment if the hospital's Medicaid utilization rate is at least 1% and if either (1) the hospital's *Medicaid utilization rate* is at least one standard deviation above the mean Medicaid utilization rate for hospitals in the State, or (2) has a *low-income utilization rate* of more than 25%.

5242 Obstetrician Requirement.
In order for a qualifying hospital to receive its adjustment, it must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetrical care to WMAP recipients. Hospitals may substitute any physician with staff privileges to perform obstetrical care and who has agreed to provide care to WMAP recipients. If a hospital serves patients predominantly under age 18, or if the hospital did not offer non-emergency obstetrical care as of December 21, 1987, it need not comply with this obstetrical requirement in order to receive the adjustment.

5243 Medicaid Utilization Method.

A hospital with high Medicaid utilization may qualify for a disproportionate share hospital (DSH) adjustment. The DSH adjustment under this "Medicaid utilization method" is provided to hospitals in the Department's annual DRG rate update. A hospital's DSH adjustment is incorporated into the hospital's specific DRG base rate and ultimately into the payment a hospital receives for each Medicaid recipient's stay.

Statewide Amounts Calculated: The Department annually calculates a "Medicaid inpatient utilization rate" for each hospital in the state that receives Medicaid payments. This is M in the following formula. From the compilation of the individual hospital utilization rates, the statewide mean average and standard deviation from the mean are calculated. The mean rate plus the amount of one standard deviation is S in the following formula.

Qualifying Hospital Under Medicaid Utilization Method: A hospital qualifies for a DSH adjustment if its Medicaid inpatient utilization rate (M) is equal to or greater than the mean-plus-one-standard-deviation (S) and is at least 1%.

Hospital Specific Adjustment Calculated: A "DSH adjustment percentage" is calculated according to the following formula for a hospital that qualifies under the Medicaid utilization method. See appendix section 27100 for amounts for current rate year.

[(M minus S) x F] + 3% where M = Hospital's Medicaid inpatient utilization rate
S = Statewide mean-plus-one-standard-deviation F = Proportional increase factor

Adjustment for Certain IMDs. The above 3% factor is increased to 11% for any hospital institution for mental disease (IMD) which qualifies for a disproportionate share hospital adjustment and has an average length of stay that exceeds 35 days for Wisconsin Medicaid recipients. Any days of a Medicaid recipient's stay that are covered in whole or part by Medicare are excluded from the calculation of the average length of stay. The average length of stay is based on the rate year that ended in the calendar year preceding the calendar year in which the current rate year begins. For example, for rates effective July 1, 1996, the base will be the rate year July 1, 1994 to June 30, 1995.

Medicaid Inpatient Utilization Rate. For purposes of the above calculation, the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for Medicaid, and the denominator of which is the total number of the hospital's inpatient days.

5300 OUTLIER PAYMENTS UNDER DRG PAYMENT SYSTEM ----------

5310 General

An outlier payment to the hospital provides a measure of relief from the financial burden presented by extremely high cost cases. It is an amount paid on an individual stay in addition to the DRG payment.

Cost based outlier adjustments and length-of-stay based outlier adjustments are provided. Each is described in detail below. If a hospital's claim qualifies under both the cost outlier and the length of stay outlier methods, then the Department shall pay under the method which gives the greater amount to the hospital.

The Department may evaluate the medical necessity of services provided and appropriateness of length of stay for all outlier cases prior to the issuance of outlier payments or, if payment has been made, recoup the same.

5320 Cost Outliers

5321 Qualifying Criteria for a Cost Outlier Payment.

For a hospital's claim to qualify for cost outlier payment, the following criteria apply:

1. The charges for a given case must be usual and customary.
2. The services provided must be medically necessary and the level of care appropriate to the medical needs of the patient.
3. The claim's cost, that is, charges-adjusted-to-cost, must exceed the DRG payment by the amount of the trimpoint applicable to the hospital. The applicable trimpoint will depend on the type and size of the hospital as follows for discharges on and after July 1, 1992.

	----- Trimpoint Amount -----	
Type of Hospital / Bed Size	Less than 100 Beds	100 Beds or Greater
General Medical & Surgical Hospitals	$ 5,235	$ 31,410
Hospital Institutions for Mental Disease (IMDs)	$ 5,460	$ 31,633
Long Term Care Hospitals	$ 24,450	$ 24,450

4. Hospital stays for which payment is not provided under the DRG payment system do not qualify for outlier payment consideration. This includes, but is not necessarily limited to, cases treated at rehabilitation hospitals and State-operated IMDs exempt from DRGs, cases treated at hospitals reimbursed on a percent-of-charges basis, and cases for services exempted from DRG payment system under section 7000. Claims for chronic, stable ventilator-dependant hospital patients shall be reimbursed under the ventilator rate and, therefore, are not eligible for a cost outlier payment.

5322 Charges Adjusted-To-Cost.

For Wisconsin Hospitals. For a hospital located in Wisconsin, claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for WMAP inpatient services. The cost-to-charges ratio to be used will be from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update except the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th prior to the annual rate update precedes the beginning date of the rate year by more than three years, three months. For cost reports to be used for combining hospitals, see §5860.

For hospitals for which the Department does not have an audited cost report, the cost-to-charge ratio from the most recent unaudited cost report available to the Department will be used. This unaudited cost-to-charge ratio will be used until the Department gets an audited cost report.

5500 DIRECT MEDICAL EDUCATION PAYMENT UNDER DRG PAYMENT SYSTEM

5510 General

As of July 1, 1997, an amount is added to a hospital's specific base DRG rate for costs of its direct medical education program. This payment amount is prospectively established based on an individual hospital's past direct costs of its medical education program. Prior to July 1, 1997, direct medical education program costs were paid under a prospectively determined monthly payment amount without regard to the number of WMP recipient discharges during the month.

5530 Calculation for Hospitals Located In Wisconsin

Base Cost Report. For hospitals located in Wisconsin, the direct medical education payment is determined from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months.

If the cost report on file is more than three years old, the hospital may request an administrative adjustment to the direct medical education payment amount pursuant to §11900, item B.

Significant changes in a hospital's direct medical education program costs after the base cost reporting period may be considered pursuant to the available administrative adjustment under section 11900, item D.

For combining hospitals, section 6480 below describes the cost report to be used for calculating the capital payment.

No Audited Cost Report Available. For hospitals located in Wisconsin for which there is no audited cost report available, an estimated direct medical education payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The direct medical education payment will be adjusted retrospectively when an audited cost report becomes available to the Department.

Calculation. The direct medical education payment for a hospital located in Wisconsin is determined from cost information from each individual hospital's base cost report. An example calculation is in section 24000 of the appendix.

1. The direct medical education cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient direct medical education costs to total allowed inpatient costs.
2. The resulting amount is inflated through the rate year by the DRI/McGraw Hill, Inc. CMS Hospital Market Basket inflation rate and increased by any disproportionate share adjustment percentage applicable to the individual hospital.
3. The resulting gross amount is divided by the number of WMP recipient discharges for the period of the audited cost report.
4. The resulting amount per discharge is divided by the average DRG case mix index per discharge .For rate year July 1, 2003 through June 30, 2004, the result is also multiplied by budget factor of .286.
5. The result is the hospital's specific base payment for its direct medical education program at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate described in section 5210.

Payment for a specific patient's stay is determined by multiplying the base payment amount by the DRG weighting factor for a specific patient's stay.

SECTION 8200
GENERAL ASSISTANCE DISPROPORTIONATE SHARE HOSPITAL ALLOWANCE

8205 Introduction.

Acute care hospitals located in major urban counties may receive a disproportionate share hospital (DSH) payment for providing a significant amount of services to low-income persons residing in those counties who are not eligible for Wisconsin Medicaid coverage. The county administered general assistance (GA) medical program identifies these low-income persons whenever they apply for general assistance from the county. The county determines a person's low-income status under financial income criteria similar to or more restrictive than eligibility income criteria for the Wisconsin Medicaid program (WMP). The county also tabulates charges for hospital services provided persons covered by the county's GA medical program and provides an annual report to the WMP. The WMP uses this information in its calculation of this DSH allowance. A major urban county is a county with 500,000 or more population.

The special payments described in this section 8200, specifically subsections 8205 through 8260, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

8210 Qualifying Criteria.

A hospital is a disproportionate share (DSH) hospital and qualifies for general assistance disproportionate share hospital payments (GA-DSH) if the hospital meets either criteria 1) or 2) below and meets all the criteria of 3) below.

1) At least 13.0% of the hospital's operating expense is attributable to services provided persons eligible for a county GA program and to persons eligible under the WMP of which at least 2.0% is attributable to services provided persons eligible for a county GA program. GA program expenses are reduced by the hospital's EACH supplement under section 8100 before calculating the above percentage.

2) At least $5,000,000 of the hospital's annual operating expense is attributable to services provided persons eligible for a county GA program and to persons eligible under the WMP which includes at least $3,500,000 attributable to services provided persons eligible for a county GA program. GA program expenses are reduced by the hospital's EACH supplement under section 8100 before applying the above qualification amounts.

3) In addition to either 1) or 2) above, the hospital must meet all of the following criteria:
   a) The hospital meets the obstetrician requirements of §5242.
   b) The hospital has a Medicaid inpatient utilization rate of at least 1% determined under §5243.
   c) The hospital or its parent corporation has a contract with the county government to serve low-income persons covered by the county's general assistance program.

For a hospital to qualify as a DSH hospital under this §8200, the hospital is <u>not required</u> to meet the qualifying criteria for DSH under §5240. In contrast, a hospital that qualifies as a DSH hospital under this §8200 can qualify for the DSH adjustment under §5240 if, and only if, the hospital meets the qualifying criteria of §5240.

8215 Calculation of Qualifying Percentages and Amounts for Individual Hospital

The amounts and percentages of operating expenses attributable to services provided to low-income GA persons and WMP recipients are determined as described in following table.

ITEM	DESCRIPTION
Total MA FFS Charges	Total fee-for-service charges by the hospital to the WMP for inpatient and outpatient services provided WMP recipients in the calendar year prior to the July 1 rate year. For example, for rate year beginning July 1, 1997, the calendar year of 1996 is used.
Total MA HMO Charges	For inpatient and outpatient services provided WMP recipients covered by Medicaid HMO or managed care contractors, total charges by the hospital in the calendar year prior to the July 1 rate year. If charges not available, zero is used
Total GA Charges	Total charges by the hospital for inpatient and outpatient services provided persons eligible for a county GA program in the calendar year prior to the July 1 rate year.
Ratio, Cost-to-Charges	The ratio of the hospital's overall costs to overall charges for hospital patient services, not to exceed 1.00, as determined from the hospital's most recent audited cost report on file with the WMP as of the effective date of the annual rate update.
Total Hospital Expenses	Total hospital patient care expenses from the hospital's most recent audited cost report on file with the WMP as of the effective date of the annual rate update.
Calculated MA & GA Expense	Total expenses attributed to inpatient and outpatient hospital services provided to WMP recipients and provided to persons eligible for a county GA program minus the hospital's EACH supplement of section 8100, calculated as: *((Total MA FFS Charges + Total MA HMO Charges + Total GA Charges) X Ratio, Cost-to-Charges)* *Minus Hospital's prior calendar year EACH Supplement of Section 8100* *and Minus Hospital's prior calendar year DSH payments of Section 5240.* This amount is compared to the $5,000,000 qualifying criteria in §8210, item 2), prior page.
Percent, MA & GA Expense	Percent of hospital's operating expenses attributable to services provided persons eligible for a county GA program and the WMP, calculated as: *Calculated MA & GA Expense* *divided by* *Total Hospital Expenses* This percent is compared to the 13.0% qualifying criteria in §8210, item 1), prior page.
Calculated GA Expense	Total expenses attributed to inpatient and outpatient hospital services provided persons eligible for a county GA program, calculated as: *(Total GA Charges X Ratio, Cost-to-Charges) Minus Hospital's EACH Supplement of Section 8100 and Minus Hospital's prior calendar year DSH payments of Section 5240.* This amount is compared to the $3,500,000 qualifying criteria in §8210, item 2), prior page.
Percent, GA Expense	Percent of hospital's operating expenses attributable to services provided persons eligible for the county GA program, calculated as: *Calculated GA Expense* *divided by* *Total Hospital Expenses* This percent is compared to the 2.0% qualifying criteria in §8210, item 1), prior page.

Calculation of Qualifying Hospital's Monthly GA-DSH Allowance

A monthly payment amount is calculated as described below for each qualifying hospital. Total payments for the rate year to all qualifying hospitals is not to exceed the maximum available funding for the GA-DSH allowance. This maximum is specified in appendix section 27100. For the individual qualifying hospital, total payments for the allowance are not to exceed the individual hospital's expenses attributable to GA services increased by a factor of 5% for inflation.

ITEM	DESCRIPTION
Sum of Calculated GA Expense for All Hospitals	Total of the "Calculated GA Expense" of all hospitals in the state that qualify for the GA-DSH supplement. This is the sum of the GA expense amounts calculated under §8215 for each of the qualifying hospitals.
Maximum Annual Funding	The maximum available funding for general assistance disproportionate share hospital payments in a rate year. The annual maximum amount for a rate year is specified in Appendix Section 27100 herein.
Ratio, Maximum Funding –to– Sum of Expenses	The percentage of the statewide GA expenses of qualifying hospitals that can be funded with the available funding, calculated as follows, limited to 100% of expenses increased by a factor of 5% for inflation. "Maximum Annual Funding" *divided by* "Sum of Calculated GA Expense for All Hospitals"
One Hospital's Monthly GA-DSH Allowance	A hospital's monthly GA-DSH allowance, based on the hospitals calculated GA expense under §8215, calculated as: *("Calculated GA Expense" X "Ratio, Maximum Funding–to–Sum of Expenses")* *divided by* *12 Months*

8260 Combining Historical Financial Statistics for Recent Hospital Combinings

Hospital combinings result from hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant.

When hospitals combine into one hospital, the required years of historical data may not be available for the combined operation for one or more rate years after the combining occurs. Whenever a required year of data is available for a full year of the combined hospital operation, then that year of data is used. However, if a full year is not available for the combined operation, then data of the individual hospitals for the required years is combined or added together for the calculations under §8210 through §8250.

(Next page is 33.6.b. Pages not used are 33.5, 33.6 and 33.6.a)

TN # 03-009
Supersedes
TN # 01-005

Approval Date APR 2 9 2004

Effective Date: 07/01/03

SECTION 10000
PAYMENT FOR SERVICES PROVIDED IN HOSPITALS OUT-OF-STATE
HOSPITALS NOT HAVING BORDER-STATUS AND MINOR BORDER STATUS HOSPITALS

10100 INTRODUCTION

Minor border status hospitals and out-of-state hospitals which do not have border status will be paid according to the DRG based payment system described in this section 10000. This payment system provides a single base DRG base rate for all minor border status and non-border status hospitals. This rate is applied to the DRG weights which have been developed for use under section 5000 for in-state hospitals and major border status hospitals. The rates do not consider hospital-specific costs or characteristics as is done for in-state and major border status hospitals. However, a minor border status hospital and a non-border status hospital may request recognition of many of these costs and characteristics through the administrative adjustments described in section 10400.

For any out-of-state hospital, border status or not, certain services will not be reimbursed according to the DRG methodology if the hospital takes the necessary action to receive reimbursement under an available alternative payment. These services and their alternative payment method are described in section 7000 and include AIDS care, ventilator patient care, special unusual cases and brain injury care.

For questions and additional information, out-of-state hospitals may contact the Department at: Hospital Unit, Bureau of Health Care Financing, P.O. Box 309, Madison, Wisconsin 53701-0309; telephone (608) 267-9595.

Any pre-established standard payment amounts which are described below and the DRG weighting factors for the current state fiscal year, July 1 through June 30 may be requested from the above address.

10200 DRG BASED PAYMENT SYSTEM For Minor Border Status and Non-Border Status Hospitals

10210 Base DRG Rate

The base DRG rate for all minor border status and non-border status hospitals shall be the standard DRG group rate which is determined under section 5160 for the hospital grouping entitled "acute care hospitals" .

10211 Wage Area Adjustment Index

For minor border status hospitals, the base DRG rate will be adjusted by the applicable wage area adjustment index which is described in section 5220. Non-border status hospitals have to take action to request a wage area administrative adjustment, under §10463 if they desire such an adjustment.

10212 Capital Cost Payment

An amount shall be added to the base DRG rate for payment of hospital capital costs. The amount shall be 100% of the average capital payment per case-mix-adjusted discharge as determined according to section 5400 for hospital located in Wisconsin. The estimate shall be based on forecasted hospital-specific capital payment rates for in-state for the rate year. A minor border status hospital and a non-border status hospital may request their capital cost payment to be adjusted pursuant to an administrative adjustment under §10464.

TN # 03-009
Supersedes
TN # 95-014

Approval Date APR 2 9 2004

Effective Date 07/01/03

Effective Period. For example, a hospital requested a capital payment adjustment under §10464 for a recipient's discharge which occurred on January 23, 1996. The hospital discharges two more WMAP recipients on May 22 and June 3 respectively. The Department will apply the capital payment adjustment to payment of these later discharges. In this example, however, a new rate year will begin on July 1, 1996 and the hospital's capital payment adjustment will lapse. The hospital will need to again request the administrative adjustment for WMAP recipient discharges occurring in the new rate year.

10460 CRITERIA FOR ADMINISTRATIVE ADJUSTMENTS

For Minor Border Status and Non-border Status Hospitals

10461 Adjustment for being a hospital institution for mental disease (IMD).

A hospital may request an administrative adjustment to its payment if (1) it is a certified hospital for a state's Title XIX program and (2) is designated as an institution for mental disease (IMD) by the certifying state or by the federal Department of Health and Human Services. The hospital must demonstrate fulfillment of these requirements to the satisfaction of the Department for approval of its request for an adjustment to recognize its IMD status.

Two adjustments may be provided. *First*, the standard DRG group rate, which is provided in section 5160 for "hospital IMDs not in Milwaukee County", may be used as the hospital's base DRG rate in place of the base DRG rate provided in subsection 10210 above. *Second*, the cost outlier trimpoints which is specified in subsection 5320 for hospital IMDs of 100 beds or greater shall be applied to the hospital. (A request can be submitted pursuant to subsection 10466 below for the trimpoint applicable to IMDs under 100 beds.)

10463 Adjustment for an area wage index.

Payment under the DRG-based payment system may be adjusted by an area wage index, as determined by the Department, upon request by a hospital. The hospital must provide the name of its CMS (Centers for Medicare & Medicaid Services) wage area for the Medicare program. Secondly, the hospital must provide its CMS assigned area wage index which was in effect at the beginning of the state's rate year in which the adjustment is desired to be effective. The state's rate year covers July 1 through June 30.

The Department shall calculate a wage index as follows. The hospital's CMS wage index will be divided by the CMS wage index for hospitals in, not reclassified to, the Madison, Wisconsin wage area. The quotient will be multiplied by the WMAP wage index for original remaining hospitals in the Madison area. The result is the wage adjustment index for the hospital. The WMAP's area wage index for Madison is listed in appendix section 27000.

The base DRG rate shall be adjusted as follows. The base DRG rate shall be reduced by that portion related to capital costs. The remaining amount will be multiplied by the wage differential factor of .7495 and that result will be multiplied by the wage adjustment index determined above for the hospital. The resulting amount plus the capital cost portion is the hospital's adjusted base DRG rate.